STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the right to be free from misappropriation of resident rroperty for 1 (Resident #1) of 8 residents reviewed for misappropriation. The facility failed to protect Resident #1's right to be free from misappropriation of resident property when there was a drug diversion of Resident #1's approximately 23 tables of Hydrocodone pills (a controlled narcotic medication). The non-compliance was identified as past non-compliance (PNC). The non-compliance began on 05/09/25 and ended on 05/10/25. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk for unrelieved pain due to their medication not being readily available. Findings included: Record review of Resident #1's Face Sheet, dated 06/17/25, reflected he was a [AGE] year-old male, who admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Resident #1's diagnoses included: end stage renal disease (a severe and irreversible decline in kidney function where the kidneys can no longer adequately filter waste and excess fluid from the blood), which requires dialysis treatment, dyspnea (an intense tightening in the chest, air hunger, difficulty breathing, breathlessness or a feeling of suffocation), hyperkalemia (having a high level of potassium in the blood), fluid overload, and pain (an unpleasant sensory and emotional experience that signals potential or actual tissue damage). Record review of Resident #1's Quarterly MDS Assessment, dated 03/18/25, reflected he had a BIMs score of 15 and his cognitive function was intact. Record review of Resident #1's Comprehensive Care Plan, dated 03/18/25, reflected: Focus: The resident has current skin concerns: (Right groin, and right proximal arm) due to Surgical Wound. Date Initiated: 05/23/2025 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 05/23/2025 Goal: Areas will heal without complications over the next 90 days. Date Initiated: 05/23/2025 Revision on: 06/17/2025 Target Date: 07/17/2025 Interventions: Assess skin weekly and record finding in clinical record. Date Initiated: 05/23/2025 Keep MD and RP informed of progress. Date Initiated: 05/23/2025 Monitor areas for increase breakdown, s/s of infection-report to MD. Date Initiated: 05/23/2025 Monitor for pain, give med per order, monitor for relief. Date Initiated: 05/23/2025 Focus: The resident is on pain medication therapy . Date Initiated: 04/11/2025 Goal: The resident will be free from any discomfort or adverse side effects from pain medication through the review date. Date Initiated: 04/11/2025 Revision on: 06/17/2025 Target Date: 07/17/2025 Interventions: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Review for pain medication efficiency, assess whether pain intensity acceptable to resident . Date Initiated: 04/11/2025. Record review of Resident #1's Physician's Order Summary, dated 06/17/25, reflected he was prescribed Hydrocodone-Acetaminophen Oral Tablet 10-325 mg tablet, Give 1 tablet by mouth orally every four hours as needed (for pain). The start date of this medication was 05/02/24 with end date of 05/07/25. Record Review of LVN B's Written Statement dated, 05/08/25 at 2 PM in the facility's Provider Investigation report dated, 05/14/25 revealed, I, [LVN B] counted Hall 6 Cart specifically narcotic and the count was accurate. Key handed over to [RN C]. Record Review of LVN A's Written Statement on 05/10/25 in the facility's Provider Investigation report dated, 05/14/25 revealed, I received a new order for pt [Resident #1] increase Norco from 7.5/325 to 10/325 Q4 PRN x 5 days following surgical procedure R/T dialysis shunt causing incision site to LT groin & RT arm. The morning following the new order I remember a card present on the 600 Hall cart with approximately 20 tablets. Pt routinely takes PRN pain meds Q4 as ordered and has verbalized he needs them Q4 to control pain. On Wednesday 5/7 pain management NP confirmed to continue order for Norco 10/325 Q4 PRN pain after pt requested Gabapentin be increased and NP unable to change med R/t kidney function. I do not recall exact amount that remained on the original card of 10/325 but I do know card was present when I left facility on Thursday 5/8 and when I returned Friday morning the only cards, I noted was the card of 7.5/325 and new script for 10/325. I gave the first pill from the new card but did not report or assume any discrepancy because I assumed card had been completed. I did not complete a control record sheet for any of pts medications and all sheets were present and count correct for my start and end of shifts. Record Review of LVN D's Written Statement on 05/11/25 in the facility's Provider Investigation report dated, 05/14/25 revealed, On May 7/8 shift worked 10pm-6a Narcotic Cart was counted as it pertained to [Resident #1's] Hydrocodone one 10-325mg card present slightly less than a full card, and Hydrocodone 7-325mg present. When medications (Pharmacy) arrived, I added a few additional cards of Hydrocodone 10-325 as received from pharmacy. Pt. asked for Hydro during evening shift of the 7th and administered per order. There were no medications missing or not counted for during shift on May 7th/8th 10pm-6am. Medications were counted with on-coming Nurse [LVN A]. No discrepancies were noted. Record Review of RN C's Written Statement on 05/09/25 in the facility's Provider Investigation report dated, 05/14/25 revealed, On 05/09/25, during medication administration, I observed that [Resident #1's] Hydrocodone -Acetaminophen 10-325 oral tab card was missing from the Medication Cart. I rechecked the Medication Cart with the Log in Slip and also discovered that the Log in Slip was missing. I notified the Nurse Supervisor [DON]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Provider Investigation Report, dated 05/14/25, reflected on 05/09/25, [RN C] notified the [DON[Resident #1's prescription medication card of Hydrocodone 10-325mg (a combination medication containing an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen), was noted to be missing (approximately 23 tablets and the narcotic log for]Resident #1's] hydrocodone were identified as missing). The DON conducted audits of the medications carts in the facility and started an investigation regarding the missing medication and log and both were not located. The pharmacy was notified and verified that [Resident #1's] medication was delivered to the facility. It was noted that Resident #1 had not missed a dose of medication, as there was still a blister pack of Hydrocodone 10-325mg (prescribed to him) on the medication cart that was being used. All appropriate parties, including the pharmacy, police department, pain management, and MD were notified of the missing medication. The staff (LVN A, LVN B, RN C and LVN E) denied diverting the medications. Staff statements revealed all individuals who had access to the medication denied taking the medication and/or knowing how the medication went missing. Drug testing revealed all individuals who had access to the medication tested negative for any substances, including Hydrocodone. The facility was unable to determine who diverted the medication or how the medication went missing along with Resident #1's narcotic log. To prevent further occurrences, the facility implemented a new form for shift count where nurses were required to count the blister packs as well as the individual sheets. There was also a new policy implemented in which the nurses were required to make a copy of all paperwork upon delivery of new narcotics and provide it to nurse management. The facility ordered new medication for Resident #1, at the cost of the facility. Facility staff were in serviced on procedures for receiving narcotics, narcotic count protocol, the implementation of new narcotic count sheets with card counts, and controlled substance accountability. All staff were in serviced on the facility's new policies and procedures. The facility replaced the resident's missing medication, continued with card count sheet along with pill counts at shift change, DON or designee will be auditing Narcotic Sheets daily. Record review of the facility's Staff Schedule for 05/09/25 revealed that LVN A and LVN D were assigned to the 600 Hall on the 6a-2p shift. LVN B and RN C was assigned the 600 Hall on the 2p - 10p shift. LVN E was assigned to work the 10p-6a shift on the 100 Hall. Record review of the facility's In Service logs, dated from 05/10/25 to 05/12/25, reflected facility staff were In-Serviced on procedures for receiving narcotics, narcotic count protocol, the implementation of new narcotic count sheets with card counts, controlled substance accountability, medication documentation and destruction. Record review of the facility's Checklist for Making Reasonable Cause Determination Training for Drug Diversion was provided to LVN A, LVN B, RN C, and LVN D from 05/11/25 to 05/12/25. Record review of the Drug Test for LVN A on 05/11/25, LVN B and RN C on 05/12 and LVN D on 05/13/25 revealed all tested negative for all drugs. Record review of the facility's Medication Audits from 05/12/25 thru 06/10/25 of all shifts revealed that all medications on Med Carts 100-600 did not have any discrepancies. Record review of personnel files for LVN A, LVN B, RN C, and LVN E reflected no concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of personnel file for LVN D reflected she was employed at the facility from 01/27/25 to 05/19/25. LVN D received a written final warning, dated 05/13/25, for failing to review company standards of documentation and expectation for real time documentation, failing to review orders and update and document conversations with NP, MD, and RP and failing to review the best practice, protocol and procedures according to facility's policy. LVN D was called by management to come to work to received In-Service Trainings and additional training but refused to come back to work and was terminated from employment at the facility. Observations of two separate medication carts on 06/17/25 from 4:00 PM to 5:00 PM, including a review of narcotic logs and count sheets, reflected no evidence of a current drug diversion. The observations revealed that facility staff were following the facility's policies and procedures to prevent a drug diversion. These observations were completed with RN C and LVN E. During interviews with multiple staff members (with LVN B, RN C, LVN E) on 06/17/25 from 11:00AM to 12:00PM, they each stated they had been in serviced on pharmacy services. They were knowledgeable of the facility's policies and procedures related to acquiring, receiving, dispensing, labeling, storing, and administering medications. They were able to verbalize the facility's policies and procedures related to the prevention of drug diversion, including the new policies and procedures implemented because of the incident involving Resident #1's prescription medication of Hydrocodone (such as what procedures to take when narcotics were received from the pharmacy as well as the procedure for counting medications). In an interview with the Administrator on 06/17/25 at 2:43 PM and 3:20PM, she stated a drug diversion occurred with Resident #1's prescription medication of Hydrocodone medication. The Administrator stated on 05/09/25 RN C reported to her supervisor RN F that a card of the Narco medication for [Resident #1] was missing along with the Narco log for the Hydrocodone for Resident #1. The Administrator stated that the DON was notified and arrived at the facility and conducted a full search for the medication and started an in-house investigation. The Administrator stated that the Narco card and log were never found during the facility's investigation. The Administrator stated that [Resident 1] was out of the facility on Leave when the Narco log and card were discovered to be missing. She stated that Resident #1 is his own RP and was notified about the missing medication upon his return to the facility. Resident #1's MD, NP and the police were notified. The facility was unable to provide an alleged perpetrator to law enforcement. The facility immediately continued their investigation, In-Service Trainings on drug diversions, implemented new procedures for the count sheets, misappropriation, and medication management. The Administrator stated that LVN A, LVN B, RN C and LVN D were given a urinalysis drug test and all were negative for all substances. LVN A, LVN B, RN C and LVN C were also provided with training on Checklist for Making Reasonable Cause Determination for Drug Diversion. The facility was unable to determine who diverted the medication. To prevent further occurrences, the facility implemented a new form for shift count where nurses were required to count the blister packs as well as the individual sheets. There was also a new policy implemented in which the nurses were required to make a copy of all paperwork upon delivery of new narcotics and provide it to nurse management. The facility ordered new medication for Resident #1, at the cost of the facility. Facility staff were in serviced on procedures for receiving narcotics, narcotic count protocol, the implementation of new narcotic count sheets with card counts, and controlled substance accountability. The Administrator stated that there was not any potential risk or harm to Resident #1 because of the drug diversion to him being out of the facility and not having any issues with pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 06/17/25 at 3:17 PM, she stated a confirmed drug diversion occurred with Resident #1's prescription medication of Hydrocodone. The DON stated because of the facility's investigation, new policies were implemented to include: a new form for shift count where nurses were required to count the blister packs as well as the individual sheets and a new policy implemented in which the nurses were required to make a copy of all paperwork upon delivery of new narcotics and provide it to nurse management. The DON was monitoring this via random audit checks for timely and proper completion by staff to ensure the prevention of another drug diversion. The Director of Nursing stated a potential risk of drug diversion was that the resident may not receive his or her prescribed dose of medication. On 06/17/25 at 3:37 PM, the surveyor attempted to contact LVN A via telephone. The surveyor left a voicemail message requesting a call back. The surveyor did not receive a return call back from LVN A prior to exiting the facility on 06/17/25. On 06/17/25 at 3:38 PM, the surveyor attempted to contact LVN D via telephone. The surveyor left a voicemail message requesting a call back. The surveyor did not receive a return call back from LVN D prior to exiting the facility on 06/17/25. On 06/17/25 at 3:40 PM, the surveyor attempted to contact the Pharmacy via telephone. The surveyor left a voicemail message requesting a call back. The surveyor did not receive a return call back from the Pharmacy prior to exiting the facility on 06/17/25. On 06/17/25 at 3:44 PM, the surveyor attempted to contact Resident #1's NP via telephone. The surveyor left a detailed voicemail message requesting a call back. The surveyor did not receive a return call back from Resident #1's NP prior to exiting the facility on 06/17/25. On 06/17/25 at 3:50PM, the surveyor attempted to contact Resident #1's PCP via telephone. The surveyor left a detailed voicemail message requesting a call back. The surveyor did not receive a return call back from Resident #1's PCP prior to exiting the facility on 06/17/25. On 06/17/2025 at 4 PM a copy of the Police Report was requested via email. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the facility's Regional Director of Clinical Services (Nurse Consultant) on 06/17/25 at 4:04 PM, she stated that on 05/09/23, the DON called her and told her that she thought the facility had a possible drug diversion with [Resident #1's] Hydrocodone medication. She stated that she asked the DON for the resident's name and she told the DON that she was out of town and would come to the facility. She stated that she told the DON to interview staff on all shifts who had access to the Medication Cart for the last 24 hours. She stated that RN C discovered that Resident #1's hydrocodone medication card and narcotic log was missing. The DON arrived at the facility and they did audits on all the medication carts in the facility and nothing else was missing. She stated that the manifest from the pharmacy stated that the facility received 2 cards of Hydrocodone medication from the pharmacy for Resident #1. She reported that they continued to search for the Narcotic Log and Narcotic Card for Resident #1 because maybe they were in the Medication Room and maybe placed in the destruction box, but they were never found. She stated that Resident #1 did not miss any Hydrocodone medications because they were given to him from the other card. She stated that LVN A, LVN B, RN C, LVN D were drug tested and interviewed. The Nurse Consultant stated that LVN A, LVN B, RN C and LVN D drug test results via urinalysis revealed that all were negative for all substances. She stated that LVN D was asked to come back to work and take In-Service Trainings, but she refused to come back to work and resigned and stated that her resignation was effective immediately. She stated that all staff including LVN A, LVN B, RN C and LVN D received In-Service Trainings on Drug Diversion, card counts and misappropriation of property. She stated that the police were notified and there were not any alleged perpetrators. She reported that Resident #1's PCP, NP and Pharmacy were notified. The Pharmacy Consultant provided staff with an In-Service Side by Side Training with all staff on Medication Count and Documentation. She reported that the facility has been doing random auditing of the medication carts and there have not been any discrepancies. She stated that staff will continue to receive ongoing trainings and documentation checks to ensure that this situation would not occur in the future. The Nurse Consultant stated that she did not feel that there was any risks or harm to Resident #1 during the drug diversion because he did not miss any doses of his medications. In an interview with Resident #1 on 06/17/25 at 4:31 PM, he stated that he has been at the facility for approximately 1 year. Resident #1 stated that he received dialysis treatment 3 x's per week due to his diagnosis of end stage renal disease. Resident #1 stated that he had not missed any dosages of his medications including Hydrocodone. Resident #1 stated that he was out on Leave from the facility when the incident occurred with his card of Hydrocodone being lost or misplaced. He stated that he was prescribed hydrocodone for pain due a surgical procedure he had last month. Resident #1 stated that he has not been without any pain medication including his prescription for Hydrocodone. He stated that if he is in pain, he will let staff know and they will provide him pain a dosage of his prescribed medication. Resident #1 stated that he felt safe at the facility and did not have any concerns regarding the staff providing his prescribed medications. Resident #1 stated that this is the first time there has been any kind of mix up with his medications. Record review of the facility's policy, Management of Controlled Medications, dated January 2024, reflected: POLICY The Facility staff will follow the method of accounting for controlled medications through receiving, administration, storage, and destruction, which meets the requirements of state and federal narcotic enforcement agencies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROCEDURE Receipt from Pharmacy 1. Upon receipt of a controlled medication, the charge nurse will verify/initial the receipt of and validate the quantity received with a second nurse/courier using the Controlled Drug Receipt/Record/Disposition Form. 2. Upon receipt, controlled medications will be logged on a Controlled Drug Receipt/Record/Disposition Form if the form did not come from pharmacy. 3. Controlled medications will immediately be placed under double lock, in the appropriate medication cart. Shift-to-Shift Count: 1. Controlled medications will be counted every shift change (scheduled or incidental) by an authorized staff member (RN/LVN/CMA) reporting on duty with an authorized staff member reporting off duty. a. Scheduled shift change = routine shift changes (8, 12, or 16 hours) b. Incidental shift change = interrupted routine shift due to any circumstances (staff illness, reassignments, partial shift work etc) 2. At the end of every shift the authorized staff member reporting on duty and the authorized staff member reporting off duty meet at the designated medication cart or storage area to count controlled medications. 3. The authorized staff member reporting off duty reads all Controlled Drug Receipt/Record/Disposition Form one sheet at a time, announcing the Patient's name, the medication, and dose. 4. The authorized staff member reporting on duty counts the amount of remaining controlled medications (bubble pack or bottle) and announces the number out loud. 5. Steps 3 and 4 are repeated for each controlled medication and/or Controlled Drug Receipt/Record/Disposition Form. 6. Both the authorized staff member reporting off duty and the authorized staff member reporting on duty verify that the count of all controlled medications and Controlled Drug Receipt/Record/Disposition Form(s) are correct and sign the Controlled Medication Count Sheet. 7. In counting controlled medications, the authorized staff member reporting on duty is alert for any evidence of a substitution. a. Inspect tablets and solutions closely. Note any defects in medication container. b. Immediately report any suspicion of substitution or tampering with controlled medications to the Director of Nursing. Generate the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate incident reports. c. If a controlled medication is discontinued or the Patient expires, the controlled medication must remain in the scheduled and/or incidental count until the Director of Nursing (DON) picks up the controlled medication for destruction. When picking up the controlled medication the DON and authorized staff member in control of the keys will both sign and date below the number of controlled medications remaining on each Controlled Drug Receipt/Record/Disposition Form. 8. The DON will log the discontinued controlled medications on the Destruction Log and place them under double lock in the designated controlled medication destruction bin until the pharmacist returns for drug destruction. 9. During the drug destruction, all narcotics will be removed from their container, placed in the biohazard bag/box and destroyed by applying liquids over them. If a discrepancy is found: a. Check the Patient notes in the chart to see if a controlled medication has been administered and not recorded. b. Check previous recordings on the Controlled Drug Receipt/Record/Disposition Form for mistakes in arithmetic or error in transferring numbers from one sheet to the next. c. If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the Director of Nursing/designee IMMEDIATELY. d. The authorized staff member reporting off duty must remain in the Facility during the investigation. e. Generate the appropriate incident statements. f. The Director of Nursing/designee will then contact the Administrator. The Administrator will determine if the incident is reportable (internal/external). The Consultant Pharmacist will be notified. Record review of the facility's policy, Identifying Exploitation, Theft and Misappropriation of Resident Property, dated April 2021, reflected: Policy Statement: As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property. Policy Interpretation and Implementation: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Exploitation, theft and misappropriation of resident property are strictly prohibited. 2. It is understood by the leadership in this facility that preventing these occurrences requires staff education and training. 3. Exploitation means taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats or coercion. 4. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. 5. Examples of misappropriation of resident property include: .f. drug diversion (taking the resident's medication) . 6. Staff and providers are expected to report suspected exploitation, theft or misappropriation of resident property. 7. The QAPI committee reviews and creates plans of action to address quality deficiencies that may lead to exploitation, theft or misappropriation of resident property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have an established system of records of receipt and disposition of all controlled drugs in place for accurate reconciliation for 1 Hall (600 Hall) of 4 halls for 1 (Resident #1) of 8 residents with orders for controlled substances. The facility failed to determine that drug records (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) were in order and that an account of all controlled drugs were maintained and reconciled for 1 (Resident #1) of 8 residents reviewed for pharmacy services. 1.The facility failed to ensure employees with access to controlled medication properly counted the inventory of the controlled medications. 2.The facility failed to ensure that approximately 23 tablets of Hydrocodone (a controlled narcotic drug), belonging to Resident #1, was not missing from the medication cart. The medication card and narcotic log for Hydrocodone for Resident #1 were never located. The non-compliance was identified as past non-compliance (PNC). The non-compliance began on 05/09/25 and ended on 05/10/25. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk for unrelieved pain due to their medication not being readily available. Findings included: Record review of Resident #1's Face Sheet, dated 06/17/25, reflected he was a [AGE] year-old male, who admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Resident #1's diagnoses included: end stage renal disease (a severe and irreversible decline in kidney function where the kidneys can no longer adequately filter waste and excess fluid from the blood), which requires dialysis treatment, dyspnea (an intense tightening in the chest, air hunger, difficulty breathing, breathlessness or a feeling of suffocation), hyperkalemia (having a high level of potassium in the blood), fluid overload, and pain (an unpleasant sensory and emotional experience that signals potential or actual tissue damage). Record review of Resident #1's Quarterly MDS Assessment, dated 03/18/25, reflected he had a BIMs score of 15 and his cognitive function was intact. Record review of Resident #1's Comprehensive Care Plan, dated 03/18/25, reflected: Focus: The resident has current skin concerns: (Right groin, and right proximal arm) due to Surgical Wound. Date Initiated: 05/23/2025 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 05/23/2025 Goal: Areas will heal without complications over the next 90 days. Date Initiated: 05/23/2025 Revision on: 06/17/2025 Target Date: 07/17/2025 Interventions: Assess skin weekly and record finding in clinical record. Date Initiated: 05/23/2025 Keep MD and RP informed of progress. Date Initiated: 05/23/2025 Monitor areas for increase breakdown, s/s of infection-report to MD. Date Initiated: 05/23/2025 Monitor for pain, give med per order, monitor for relief. Date Initiated: 05/23/2025 Focus: The resident is on pain medication therapy . Date Initiated: 04/11/2025 Goal: The resident will be free from any discomfort or adverse side effects from pain medication through the review date. Date Initiated: 04/11/2025 Revision on: 06/17/2025 Target Date: 07/17/2025 Interventions: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Review for pain medication efficiency, assess whether pain intensity acceptable to resident . Date Initiated: 04/11/2025. Record review of Resident #1's Physician's Order Summary, dated 06/17/25, reflected he was prescribed Hydrocodone-Acetaminophen Oral Tablet 10-325 mg tablet, Give 1 tablet by mouth orally every four hours as needed (for pain). The start date of this medication was 05/02/24 with end date of 05/07/25. Record Review of LVN B's Written Statement dated, 05/08/25 at 2 PM in the facility's Provider Investigation report dated, 05/14/25 revealed, I, [LVN B] counted Hall 6 Cart specifically narcotic and the count was accurate. Key handed over to [RN C]. Record Review of LVN A's Written Statement on 05/10/25 in the facility's Provider Investigation report dated, 05/14/25 revealed, I received a new order for pt [Resident #1] increase Norco from 7.5/325 to 10/325 Q4 PRN x 5 days following surgical procedure R/T dialysis shunt causing incision site to LT groin & RT arm. The morning following the new order I remember a card present on the 600 Hall cart with approximately 20 tablets. Pt routinely takes PRN pain meds Q4 as ordered and has verbalized he needs them Q4 to control pain. On Wednesday 5/7 pain management NP confirmed to continue order for Norco 10/325 Q4 PRN pain after pt requested Gabapentin be increased and NP unable to change med R/t kidney function. I do not recall exact amount that remained on the original card of 10/325 but I do know card was present when I left facility on Thursday 5/8 and when I returned Friday morning the only cards, I noted was the card of 7.5/325 and new script for 10/325. I gave the first pill from the new card but did not report or assume any discrepancy because I assumed card had been completed. I did not complete a control record sheet for any of pts medications and all sheets were present and count correct for my start and end of shifts. Record Review of LVN D's Written Statement on 05/11/25 in the facility's Provider Investigation report dated, 05/14/25 revealed, On May 7/8 shift worked 10pm-6a Narcotic Cart was counted as it pertained to [Resident #1's] Hydrocodone one 10-325mg card present slightly less than a full card, and Hydrocodone 7-325mg present. When medications (Pharmacy) arrived, I added a few additional cards of Hydrocodone 10-325 as received from pharmacy. Pt. asked for Hydro during evening shift of the 7th and administered per order. There were no medications missing or not counted for during shift on May 7th/8th 10pm-6am. Medications were counted with on-coming Nurse [LVN A]. No discrepancies were noted. Record Review of RN C's Written Statement on 05/09/25 in the facility's Provider Investigation report dated, 05/14/25 revealed, On 05/09/25, during medication administration, I observed that [Resident #1's] Hydrocodone -Acetaminophen 10-325 oral tab card was missing from the Medication Cart. I rechecked the Medication Cart with the Log in Slip and also discovered that the Log in Slip was missing. I notified the Nurse Supervisor [DON]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Provider Investigation Report, dated 05/14/25, reflected on 05/09/25, [RN C] notified the [DON[Resident #1's prescription medication card of Hydrocodone 10-325mg (a combination medication containing an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen), was noted to be missing (approximately 23 tablets and the narcotic log for]Resident #1's] hydrocodone were identified as missing). The DON conducted audits of the medications carts in the facility and started an investigation regarding the missing medication and log and both were not located. The pharmacy was notified and verified that [Resident #1's] medication was delivered to the facility. It was noted that Resident #1 had not missed a dose of medication, as there was still a blister pack of Hydrocodone 10-325mg (prescribed to him) on the medication cart that was being used. All appropriate parties, including the pharmacy, police department, pain management, and MD were notified of the missing medication. The staff (LVN A, LVN B, RN C and LVN E) denied diverting the medications. Staff statements revealed all individuals who had access to the medication denied taking the medication and/or knowing how the medication went missing. Drug testing revealed all individuals who had access to the medication tested negative for any substances, including Hydrocodone. The facility was unable to determine who diverted the medication or how the medication went missing along with Resident #1's narcotic log. To prevent further occurrences, the facility implemented a new form for shift count where nurses were required to count the blister packs as well as the individual sheets. There was also a new policy implemented in which the nurses were required to make a copy of all paperwork upon delivery of new narcotics and provide it to nurse management. The facility ordered new medication for Resident #1, at the cost of the facility. Facility staff were in serviced on procedures for receiving narcotics, narcotic count protocol, the implementation of new narcotic count sheets with card counts, and controlled substance accountability. All staff were in serviced on the facility's new policies and procedures. The facility replaced the resident's missing medication, continued with card count sheet along with pill counts at shift change, DON or designee will be auditing Narcotic Sheets daily. Record review of the facility's Staff Schedule for 05/09/25 revealed that LVN A and LVN D were assigned to the 600 Hall on the 6a-2p shift. LVN B and RN C was assigned the 600 Hall on the 2p - 10p shift. LVN E was assigned to work the 10p-6a shift on the 100 Hall. Record review of the facility's In Service logs, dated from 05/10/25 to 05/12/25, reflected facility staff were In-Serviced on procedures for receiving narcotics, narcotic count protocol, the implementation of new narcotic count sheets with card counts, controlled substance accountability, medication documentation and destruction. Record review of the facility's Checklist for Making Reasonable Cause Determination Training for Drug Diversion was provided to LVN A, LVN B, RN C, and LVN D from 05/11/25 to 05/12/25. Record review of the Drug Test for LVN A on 05/11/25, LVN B and RN C on 05/12 and LVN D on 05/13/25 revealed all tested negative for all drugs. Record review of the facility's Medication Audits from 05/12/25 thru 06/10/25 of all shifts revealed that all medications on Med Carts 100-600 did not have any discrepancies. Record review of personnel files for LVN A, LVN B, RN C, and LVN E reflected no concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of personnel file for LVN D reflected she was employed at the facility from 01/27/25 to 05/19/25. LVN D received a written final warning, dated 05/13/25, for failing to review company standards of documentation and expectation for real time documentation, failing to review orders and update and document conversations with NP, MD, and RP and failing to review the best practice, protocol and procedures according to facility's policy. LVN D was called by management to come to work to received In-Service Trainings and additional training but refused to come back to work and was terminated from employment at the facility. Observations of two separate medication carts on 06/17/25 from 4:00 PM to 5:00 PM, including a review of narcotic logs and count sheets, reflected no evidence of a current drug diversion. The observations revealed that facility staff were following the facility's policies and procedures to prevent a drug diversion. These observations were completed with RN C and LVN E. During interviews with multiple staff members (with LVN B, RN C, LVN E) on 06/17/25 from 11:00AM to 12:00PM, they each stated they had been in serviced on pharmacy services. They were knowledgeable of the facility's policies and procedures related to acquiring, receiving, dispensing, labeling, storing, and administering medications. They were able to verbalize the facility's policies and procedures related to the prevention of drug diversion, including the new policies and procedures implemented because of the incident involving Resident #1's prescription medication of Hydrocodone (such as what procedures to take when narcotics were received from the pharmacy as well as the procedure for counting medications). In an interview with the Administrator on 06/17/25 at 2:43 PM and 3:20PM, she stated a drug diversion occurred with Resident #1's prescription medication of Hydrocodone medication. The Administrator stated on 05/09/25 RN C reported to her supervisor RN F that a card of the Narco medication for [Resident #1] was missing along with the Narco log for the Hydrocodone for Resident #1. The Administrator stated that the DON was notified and arrived at the facility and conducted a full search for the medication and started an in-house investigation. The Administrator stated that the Narco card and log were never found during the facility's investigation. The Administrator stated that [Resident 1] was out of the facility on Leave when the Narco log and card were discovered to be missing. She stated that Resident #1 is his own RP and was notified about the missing medication upon his return to the facility. Resident #1's MD, NP and the police were notified. The facility was unable to provide an alleged perpetrator to law enforcement. The facility immediately continued their investigation, In-Service Trainings on drug diversions, implemented new procedures for the count sheets, misappropriation, and medication management. The Administrator stated that LVN A, LVN B, RN C and LVN D were given a urinalysis drug test and all were negative for all substances. LVN A, LVN B, RN C and LVN C were also provided with training on Checklist for Making Reasonable Cause Determination for Drug Diversion. The facility was unable to determine who diverted the medication. To prevent further occurrences, the facility implemented a new form for shift count where nurses were required to count the blister packs as well as the individual sheets. There was also a new policy implemented in which the nurses were required to make a copy of all paperwork upon delivery of new narcotics and provide it to nurse management. The facility ordered new medication for Resident #1, at the cost of the facility. Facility staff were in serviced on procedures for receiving narcotics, narcotic count protocol, the implementation of new narcotic count sheets with card counts, and controlled substance accountability. The Administrator stated that there was not any potential risk or harm to Resident #1 because of the drug diversion to him being out of the facility and not having any issues with pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 06/17/25 at 3:17 PM, she stated a confirmed drug diversion occurred with Resident #1's prescription medication of Hydrocodone. The DON stated because of the facility's investigation, new policies were implemented to include: a new form for shift count where nurses were required to count the blister packs as well as the individual sheets and a new policy implemented in which the nurses were required to make a copy of all paperwork upon delivery of new narcotics and provide it to nurse management. The DON was monitoring this via random audit checks for timely and proper completion by staff to ensure the prevention of another drug diversion. The Director of Nursing stated a potential risk of drug diversion was that the resident may not receive his or her prescribed dose of medication. On 06/17/25 at 3:37 PM, the surveyor attempted to contact LVN A via telephone. The surveyor left a voicemail message requesting a call back. The surveyor did not receive a return call back from LVN A prior to exiting the facility on 06/17/25. On 06/17/25 at 3:38 PM, the surveyor attempted to contact LVN D via telephone. The surveyor left a voicemail message requesting a call back. The surveyor did not receive a return call back from LVN D prior to exiting the facility on 06/17/25. On 06/17/25 at 3:40 PM, the surveyor attempted to contact the Pharmacy via telephone. The surveyor left a voicemail message requesting a call back. The surveyor did not receive a return call back from the Pharmacy prior to exiting the facility on 06/17/25. On 06/17/25 at 3:44 PM, the surveyor attempted to contact Resident #1's NP via telephone. The surveyor left a detailed voicemail message requesting a call back. The surveyor did not receive a return call back from Resident #1's NP prior to exiting the facility on 06/17/25. On 06/17/25 at 3:50PM, the surveyor attempted to contact Resident #1's PCP via telephone. The surveyor left a detailed voicemail message requesting a call back. The surveyor did not receive a return call back from Resident #1's PCP prior to exiting the facility on 06/17/25. On 06/17/2025 at 4 PM a copy of the Police Report was requested via email. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the facility's Regional Director of Clinical Services (Nurse Consultant) on 06/17/25 at 4:04 PM, she stated that on 05/09/23, the DON called her and told her that she thought the facility had a possible drug diversion with [Resident #1's] Hydrocodone medication. She stated that she asked the DON for the resident's name and she told the DON that she was out of town and would come to the facility. She stated that she told the DON to interview staff on all shifts who had access to the Medication Cart for the last 24 hours. She stated that RN C discovered that Resident #1's hydrocodone medication card and narcotic log was missing. The DON arrived at the facility and they did audits on all the medication carts in the facility and nothing else was missing. She stated that the manifest from the pharmacy stated that the facility received 2 cards of Hydrocodone medication from the pharmacy for Resident #1. She reported that they continued to search for the Narcotic Log and Narcotic Card for Resident #1 because maybe they were in the Medication Room and maybe placed in the destruction box, but they were never found. She stated that Resident #1 did not miss any Hydrocodone medications because they were given to him from the other card. She stated that LVN A, LVN B, RN C, LVN D were drug tested and interviewed. The Nurse Consultant stated that LVN A, LVN B, RN C and LVN D drug test results via urinalysis revealed that all were negative for all substances. She stated that LVN D was asked to come back to work and take In-Service Trainings, but she refused to come back to work and resigned and stated that her resignation was effective immediately. She stated that all staff including LVN A, LVN B, RN C and LVN D received In-Service Trainings on Drug Diversion, card counts and misappropriation of property. She stated that the police were notified and there were not any alleged perpetrators. She reported that Resident #1's PCP, NP and Pharmacy were notified. The Pharmacy Consultant provided staff with an In-Service Side by Side Training with all staff on Medication Count and Documentation. She reported that the facility has been doing random auditing of the medication carts and there have not been any discrepancies. She stated that staff will continue to receive ongoing trainings and documentation checks to ensure that this situation would not occur in the future. The Nurse Consultant stated that she did not feel that there was any risks or harm to Resident #1 during the drug diversion because he did not miss any doses of his medications. In an interview with Resident #1 on 06/17/25 at 4:31 PM, he stated that he has been at the facility for approximately 1 year. Resident #1 stated that he received dialysis treatment 3 x's per week due to his diagnosis of end stage renal disease. Resident #1 stated that he had not missed any dosages of his medications including Hydrocodone. Resident #1 stated that he was out on Leave from the facility when the incident occurred with his card of Hydrocodone being lost or misplaced. He stated that he was prescribed hydrocodone for pain due a surgical procedure he had last month. Resident #1 stated that he has not been without any pain medication including his prescription for Hydrocodone. He stated that if he is in pain, he will let staff know and they will provide him pain a dosage of his prescribed medication. Resident #1 stated that he felt safe at the facility and did not have any concerns regarding the staff providing his prescribed medications. Resident #1 stated that this is the first time there has been any kind of mix up with his medications. Record review of the facility's policy, Management of Controlled Medications, dated January 2024, reflected: POLICY The Facility staff will follow the method of accounting for controlled medications through receiving, administration, storage, and destruction, which meets the requirements of state and federal narcotic enforcement agencies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROCEDURE Receipt from Pharmacy 1. Upon receipt of a controlled medication, the charge nurse will verify/initial the receipt of and validate the quantity received with a second nurse/courier using the Controlled Drug Receipt/Record/Disposition Form. 2. Upon receipt, controlled medications will be logged on a Controlled Drug Receipt/Record/Disposition Form if the form did not come from pharmacy. 3. Controlled medications will immediately be placed under double lock, in the appropriate medication cart. Shift-to-Shift Count: 1. Controlled medications will be counted every shift change (scheduled or incidental) by an authorized staff member (RN/LVN/CMA) reporting on duty with an authorized staff member reporting off duty. a. Scheduled shift change = routine shift changes (8, 12, or 16 hours) b. Incidental shift change = interrupted routine shift due to any circumstances (staff illness, reassignments, partial shift work etc) 2. At the end of every shift the authorized staff member reporting on duty and the authorized staff member reporting off duty meet at the designated medication cart or storage area to count controlled medications. 3. The authorized staff member reporting off duty reads all Controlled Drug Receipt/Record/Disposition Form one sheet at a time, announcing the Patient's name, the medication, and dose. 4. The authorized staff member reporting on duty counts the amount of remaining controlled medications (bubble pack or bottle) and announces the number out loud. 5. Steps 3 and 4 are repeated for each controlled medication and/or Controlled Drug Receipt/Record/Disposition Form. 6. Both the authorized staff member reporting off duty and the authorized staff member reporting on duty verify that the count of all controlled medications and Controlled Drug Receipt/Record/Disposition Form(s) are correct and sign the Controlled Medication Count Sheet. 7. In counting controlled medications, the authorized staff member reporting on duty is alert for any evidence of a substitution. a. Inspect tablets and solutions closely. Note any defects in medication container. b. Immediately report any suspicion of substitution or tampering with controlled medications to the Director of Nursing. Generate the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate incident reports. c. If a controlled medication is discontinued or the Patient expires, the controlled medication must remain in the scheduled and/or incidental count until the Director of Nursing (DON) picks up the controlled medication for destruction. When picking up the controlled medication the DON and authorized staff member in control of the keys will both sign and date below the number of controlled medications remaining on each Controlled Drug Receipt/Record/Disposition Form. 8. The DON will log the discontinued controlled medications on the Destruction Log and place them under double lock in the designated controlled medication destruction bin until the pharmacist returns for drug destruction. 9. During the drug destruction, all narcotics will be removed from their container, placed in the biohazard bag/box and destroyed by applying liquids over them. If a discrepancy is found: a. Check the Patient notes in the chart to see if a controlled medication has been administered and not recorded. b. Check previous recordings on the Controlled Drug Receipt/Record/Disposition Form for mistakes in arithmetic or error in transferring numbers from one sheet to the next. c. If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the Director of Nursing/designee IMMEDIATELY. d. The authorized staff member reporting off duty must remain in the Facility during the investigation. e. Generate the appropriate incident statements. f. The Director of Nursing/designee will then contact the Administrator. The Administrator will determine if the incident is reportable (internal/external). The Consultant Pharmacist will be notified. Record review of the facility's policy, Identifying Exploitation, Theft and Misappropriation of Resident Property, dated April 2021, reflected: Policy Statement: As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property. Policy Interpretation and Implementation: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Exploitation, theft and misappropriation of resident property are strictly prohibited. 2. It is understood by the leadership in this facility that preventing these occurrences requires staff education and training. 3. Exploitation means taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats or coercion. 4. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. 5. Examples of misappropriation of resident property include: .f. drug diversion (taking the resident's medication) . 6. Staff and providers are expected to report suspected exploitation, theft or misappropriation of resident property. 7. The QAPI committee reviews and creates plans of action to address quality deficiencies that may lead to exploitation, theft or misappropriation of resident property.